Community Behavioral Healthcare Association of Illinois

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House Appropriations-Human Services Committee
House Human Services Committee
Subject Matter: Regarding 1115 Medicaid DRAFT Waiver Application
January 22, 2014, 10:00 a.m.
Michael A. Bilandic Building, 6th Floor, Room C-600, Chicago

I would like to thank the committee chairs and members of the House Joint Committees for this opportunity to provide input into the ***1115 DRAFT Waiver Application discussion.***

We applaud the fact the *Waiver DRAFT Application "*The *Path to Transformation" identifies* the need to develop Integrated Delivery of Health Care and add additional capacity in community mental and substance use care, treatment, services and related supports.

We have two overarching questions:

1. **What "markers or benchmarks" will be used in the development and negotiation of the Waiver and implementation of the Waiver services and the Waiver's Pathways?**
2. **Will financing and investment strategies for community mental health and substance use care, treatment and services be comparable to those outlined within the DRAFT under Hospital/Health System Transformation and Nursing Facility Transformation? Will those comparable strategies be included in the waiver application submitted to CMS?** (Appendix II, page 5, offers one example of omitted financing requirements needing to be corrected prior to the submission of the application.)

Markers/benchmarks along the ***Transformation Pathway*** are necessary to accelerate developments in regions across the state. To improve the health of the population, quality and control costs, expanded community capacity is one of the **markers or benchmarks** for the successful development of the ***Pathways to Transformation***. **For FY 2015, expanded community capacity may also be a benchmark** to ascertain commitment to address the numbers of newly eligible individuals under the Medicaid expansion that require community mental health and substance use care, treatment, service, prevention, housing and related supports.

As mentioned above, financing and investment strategies are an overarching question. The **DRAFT** mentions consolidating the existing nine waivers and adding:

- Redesigned Mental and Substance Use disorders and conditions care, treatment and services - pages 34, 39
- Justice involved populations - page 15

By itself, redesigning Mental and Substance Use care, treatment and services will not be sufficient to address the financial requirements necessary for developing and expanding networks to provide integrated care. Therefore, one omission in the current DRAFT we ask be inserted into the application submission are the financing and investment strategies for community mental health and substance use care, treatment, services, prevention, housing and related supports which are necessary to "***Transform"*** Integrated Delivery Systems, networks and Waiver services in the proposed ***Transformation.***

Integrated Delivery Systems inclusive of complex mental and substance use disorders or conditions require that the ***Waiver Application*** identify the financing and models that ***Transform*** appropriation, financing, reimbursement and contracting legacies across the state's 102 counties to:

1. safely Transform community mental and substance use care, treatment, services, prevention and related supported to include health home and systems of care;
2. develop the mental and substance use disorders or conditions work force;
3. close gaps in health care and community mental and substance use care, treatment and service disparities;
4. support "tele"-health community mental and substance use care, treatment, and services, prevention and supports;
5. bridge ***Pathways*** financing, incentives and supports for Health Homes and Systems of Care services and models for Integrated Delivery Systems inclusive of community mental and substance use care, treatment, services and supports;
6. support information technology necessary to manage and deliver Integrated Care as community mental and substance use care, treatment, services, prevention and supports are the appropriate care. Worth noting is the fact that community providers were excluded from the ACA Technology financing and incentives;
7. develop adequate Integrated Delivery System networks across the state for those with complex mental and substance use disorders or conditions including peer supports, housing and ensuring linkages and interfaces with support services occur.

We suggest the state ensures the *Waiver Application* includes:

A) Developing a safe transition from the current grants and FFS financial models to the envisioned enhanced community-based services to meet the directions of the Waiver and the objectives of the Triple Aim:

i) Financially support outreach, engagement and intensive case management for populations with complex mental and substance use disorders or conditions.
ii) Adopt and financially support Health Home Model services across departments as a model for the safe transition to enhancing these community-based services.
iii) Recognize and financially support the specific service array meant to serve children and adults must meet the different needs of these populations.

B) Financially addressing substandard financing and rates in order to maintain and expand the community care, treatment and services for mental and substance use disorders or conditions: In order to maintain current community care, treatment and services for mental and substance use disorders or conditions, reimbursement for community care, treatment, service, prevention, housing, and supports, including substandard rates, must be addressed.

C) Includes Expansion, Diversity, Loan Forgiveness and Training of the mental health and substance use health care workforce, specialists and peer supports:

i) We request that allied health professionals, social workers, interdisciplinary primary and community-based team members, including peer counselors, be included in the list of "health care professions and workers" that the state prioritizes to improve the diversity of this workforce and for those eligible to receive loan forgiveness and workforce training grants.

D) Builds capacity across departments of Health Care Systems for Population Health Management:

i) Health Homes and Systems of Care services and models. Expanding on the Medical Model by using outreach, engagement and intensive case management fees to directly support Integrated Delivery Systems that are inclusive of the Medicaid population with co-morbidities, including mental illness, substance use disorders and chronic health conditions is a solution Illinois needs to systematically develop so that Health Homes and Systems of Care can be utilized "across" departments to address complex mental health and substance use disorders and conditions.

Please see:

- Financing and Policy Considerations for Medicaid Health Homes for Individuals with Behavioral Health Conditions. April 15, 2013 http://www.integration.samhsa.gov/about-us/Financing_HHs_Webinar_Presentation.pdf
- Health Homes for Children with Serious BH Challenges http://www.chcs.org/usr_doc/Customizing_Health_Homes_for_Children_with_Serious_BH_Challenges_-_SPires.pdf

E) Financing and investment strategies comparable to those outlined under Hospital/Health System Transformation and Nursing Facility Transformation must be included in the waiver application submitted to CMS.

In the ***Draft,*** the referenced investment strategies outlined under Hospital/Health System Transformation and Nursing Facility Transformation include:

i) Development and implementation of one or more incentive-based pools to drive transformation of systems, including, but not limited to:
   a. care development, quality care improvements, and regional collaborations on state public health initiatives and community needs;
   b. development of integrated delivery systems, including HIT/HIE infrastructure, governance and care models;
   c. development, implementation and training on effective transitions of care models;
   d. technical assistance to support the development of integrated delivery systems that are capable of assuming responsibility for the health care of a defined population;
   e. an access assurance pool to cover uninsured and unreimbursed Medicaid costs to assure access and preserve the "safety net"; development and implementation of a pool to support debt relief or capital investments for providers that commit to redesigning, downsizing or closing some or all of their facilities, including transformation of rural systems to potentially create rural "hubs";
   f. debt relief or capital investments for nursing facilities that commit to redesigning, downsizing or closing some or all of their facilities, including technical assistance in developing new business models to retool facilities to meet the needs of emerging populations;
   g. flexibility to develop and fund additional supportive housing and employment options for those populations in need of long-term care.

Appendix I -- To improve Quality, Outcomes and Bend the Cost Curve. Lessons Learned.

NY Chronic Illness Demonstration Project

- 2013 data show clients in the program for at least two years experienced a 45 percent reduction in the number of hospital admissions and a 15 percent decrease in ER visits, compared with two years prior to enrollment.
- Providers were paid for Health Home services, with Medicaid paying separately for each beneficiary's standard health care benefits.
  http://www.integration.samhsa.gov/about-us/webinars

Missouri

- 'Health home' initiative shows $4.2M savings in first year.
- Savings were in hospital and emergency room Medicaid costs of 19,000 patients.
  Mike Sherry, KHI News Service, June 25, 2013

Illinois **SMI patients who received CMHC services 13% less cost, 18% fewer hospitalizations.**
Comparing SMI patients who received CMHC services to SMI patients who did not, costs were 13% less, with 18% fewer hospitalizations*!

	Not in CMHC Services	Receiving CMHC Services
Cost	$13,095	$11,390
Hospitalizations	41,209	33,777

Illinois Behavioral Health Home Coalition

* Key observations for individuals in the Coalition's geographic area. As reported by Heritage Behavioral Health Center's Diana Knaebe, Decatur, Illinois. Data analytics conduced by Care Management Technologies.

Illinois **SASS avoids approximately $19 million per year in costs.**
Screening, Assessment and Support Services (SASS) System. "SASS is estimated to **avoid approximately $19 million per year in costs to the state** for unnecessary psychiatric inpatient hospitalization and related costs." *

*Healthcare and Family Services' Annual Report to the Governor FY'13 Report on Community Screening, Assessment and Support Services - the Illinois Children's Mental Health Partnership (ICMHP).

Illinois **Adult Redeploy**
Since 2011, 10 sites in full implementation have diverted 838 non-violent offenders, or the equivalent of two cellblocks of a prison. The evidence-based practices utilized by the current sites have been shown by research to reduce recidivism by as much as 20%. ARI also demonstrates significant cost savings while reducing pressure on the system and increasing public safety.

In 2012, sites spent an average of $2,233 per ARI participant, compared to the annual per capita incarceration cost of $21,500 (FY11). Based on the 838 offenders diverted, this represents $16.1 million in potential corrections savings.*

*2012 Annual Report to the Governor and General Assembly on the Implementation and Projected Impact of Adult Redeploy Illinois.

Illinois **Redeploy for Youth**
Because of the alternative path offered by Redeploy, Redeploy counties have committed only 174 youth per year on average since 2006, a 51% reduction, averting millions in annual incarceration costs to the state:

- Analysis indicates that only 17.4% of youth who successfully completed Redeploy services were arrested on new charges during the period covered by the study, compared to 72.8% of juvenile justice-involved youth not in Redeploy.
- Further, the rate of re-incarceration among Redeploy participants was 14.2%, compared to 57.4% among non-participants.

Appendix II – Health Homes – An example of omitted financing references which should be corrected prior to the submission of the *Waiver Application* to CMS.

Aligning accountability, financial incentives, appropriations, financing reimbursements and contracting.

Health Homes are one of the solutions reviewers will find elevated throughout the ***DRAFT 1115 WAIVER Application.*** Health Homes (pages 10, 11, 35, 37) are required for Accountable Care Entities (ACE) and Care Coordination Entities (CCE) and also have been rolled out in other states.

Health Homes and Health Home requirements should, therefore, be developed into financially feasible "models" within appropriation, financing, reimbursement and contracting in the Waiver Application in FY 2015 and to be sustainable in future years.

As mentioned in page 1 of the testimony:

- *"By itself a redesigned system will not be sufficient to address financial requirements necessary for developing and expanding networks providing integrated care. One omission in the current DRAFT we ask be corrected in the application submission is the omission of financing and investment strategies to "Transform" community mental health and substance use care, treatment and services."*

The Transformation should include the alignment of financial requirement and Behavioral Health Home Standards

In addition to using lessons learned from Integrated Delivery programs in Illinois at this juncture, one should also review Behavioral Health Home Joint Commission, Council on Accreditation and Council of Accreditation of Rehabilitation Facilities standards.

Our review reveals costs that should be part of the alignment of financial models for "Health Homes". To identify some of the costs we believe need to be built into ***Transforming*** Illinois "siloed" care, treatment and services, we provide our brief summary of Health Home Standards from the three accreditation bodies:

> Behavioral Health Homes are responsible for the integration and coordination of the individual's health care (physical and behavioral)…they must ensure that the full array of primary and health care services are available, integrated and coordinated. (Joint Commission)
>
> Health home is a healthcare delivery system approach that focuses on the whole person and provides integrated healthcare coordination that includes primary care and behavioral healthcare…A health home serving individuals receiving specialized behavioral healthcare provides screening, evaluation, crisis intervention, medication management, psychosocial treatment and rehabilitation, care management, and community integration and support services designed to assist individuals in addressing their behavioral healthcare needs (CARF)

1. Recovery-focused model (Not currently funded)
2. Provides healthy lifestyles and provides prevention and education services that focus on wellness and self-care (Not currently funded)
3. Ensures access to and coordinates care across prevention, primary care, and specialty healthcare services (Not currently funded)
4. Monitors critical health indicators (Not currently funded)
5. Coordinates/monitors emergency room visits and hospitalizations, including participating in transition/discharge planning and follow-up (Not a fully funded activity)

Integrated Behavioral Health and Primary Care is the systematic coordination of behavioral and physical healthcare to improve the overall health of clients…organizations that offer integrated behavioral health and primary care have the capacity to assess, identify, and coordinate treatment for mental health, substance use, and general medical conditions, using an interdisciplinary team of behavioral health primary care professionals. (COA) (Not funded)

Health Information Technology

CARF, COA and Joint Commission all reference the importance of the use of health information technology for the health home to collect, aggregate and analyze individual healthcare data. Worth noting is the fact that community providers were excluded from the ACA Technology financing and incentives.

Infrastructure or Services currently either not funded or only partially financially supported.

1. Care management that includes "Outreach" and "Engagement" (Currently neither of these service activities are funded)

2. Comprehensive Care Coordination (Not fully funded)

3. Prevention and/or Early Intervention Services mentioned in CARF, COA, and Joint Commission (Not funded)

4. The Health Assessment Screening for Chronic disease status – diabetes, hypertension, cardiovascular disease, Asthma/COPD. Can be woven into medical part of Mental Health Assessment and billed. Staffing availability, staffing configurations and rate setting will need to be reviewed.

   IT for patient registries to proactively manage the health home population through tracking data. Worth noting is the fact that community providers were excluded from the ACA Technology financing and incentives. Ensuring financial incentives are aligned to ensure this functionality becomes commonplace is necessary.

5. Development of performance measurement indicators to address how service delivery responds to the needs of the persons served in an integrated/holistic manner. Performance measures utilized to date are dominated by medical and institutional models. Non redundant measures that are able to discern the individuals needs for community mental health and substance use care, treatment, service, prevention, housing and related supports will need attention including financial support of the effort to develop and support these measures.